MARCH 2015

PAYER-PROVIDER STRATEGIES:
New Rules for Facing Risk Together
NEW REPORT reveals how top providers and payers are finding new and better ways to align incentives and share risk.

- Get examples of how North Shore-LIJ Health System and its CareConnect health plan subsidiary use shared data and shared clinical practice guidelines to align incentives
- Find out the key discipline that payers have mastered and that providers must learn, or at least better understand
- Learn how Crystal Run Healthcare’s care standards for diabetes patients helped to reduce office-related charges by about 9% and hospital admissions by about 14%
- Find out how UPMC Health Plan has saved nearly $15 million in medical costs since converting its primary care practices to its version of the patient-centered medical home model
- Get peer-tested best practices and a meeting guide to steer constructive dialogue in your organization

For more information or to purchase this report, go to HealthLeadersMedia.com/Intelligence or call 800-753-0131.
About the Premium and Buying Power Editions

This is a summary of the Premium edition of the report. In the full report, you’ll find a wealth of additional information. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you’ll also get the tools you need to turn the data into decisions:

- A Foreword by Diane Holder, President and CEO of UPMC Health Plan in Pittsburgh and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by North Shore-LIJ CareConnect Insurance Company, Inc., in East Hills, New York; Crystal Run Healthcare in Middletown, New York; and UPMC Health Plan in Pittsburgh
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team
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Methodology

The 2015 Payer-Provider Strategies Survey was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In December 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 304 completed surveys are included in the analysis. The margin of error for a sample size of 304 is +/-5.6% at the 95% confidence interval.

Each figure presented in the report contains the following segmentation data: setting, number of beds (hospitals), number of sites (health systems), net patient revenue, and region. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

Diane Holder
President and CEO
UPMC Health Plan
Pittsburgh

Hal Teitelbaum, MD, JD, MBA
Founder, managing partner, and CEO
Crystal Run Healthcare
Middletown, New York

Alan Murray
President, CEO
North Shore-LIJ CareConnect Insurance Company, Inc.
East Hills, New York

UPCOMING INTELLIGENCE REPORT TOPICS

APRIL
Healthcare IT and Analytics

MAY
Emergency Department Strategies

JUNE
Strategic Cost Control

JULY
Care Continuum Coordination

AUGUST
Patient Experience

SEPTEMBER
Physician-Hospital Alignment

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

Intelligence Report Senior Research Analyst
MICHAEL ZEIS
mzeis@healthleadersmedia.com

Intelligence Report Research Editor-Analyst
JONATHAN BEES
jbees@healthleadersmedia.com

Vice President and Publisher
RAFAEL CARDOSO
rcardoso@healthleadersmedia.com

Editorial Director
EDWARD PREWITT
eprwitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bverture@healthleadersmedia.com

Intelligence Unit Director
ANN MACKAY
amackay@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

Intelligence Report Contributing Editor
DON COSTANZO
dcostanzo@healthleadersmedia.com

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Respondent Profile

Respondents represent titles from across the various functions at hospitals, health systems, and physician organizations.

<table>
<thead>
<tr>
<th>Title</th>
<th>Base = 304</th>
</tr>
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<tbody>
<tr>
<td>Senior leaders</td>
<td>54%</td>
</tr>
<tr>
<td>Clinical leaders</td>
<td>19%</td>
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<tr>
<td>Operations leaders</td>
<td>16%</td>
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<tr>
<td>Marketing leaders</td>
<td>7%</td>
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<td>Financial leaders</td>
<td>3%</td>
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<tr>
<td>Information leaders</td>
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</tbody>
</table>

**Type of organization**

- Base = 304
  - Health system 39%
  - Hospital 32%
  - Physician organization 29%

**Number of beds**

- Base = 118 (Hospitals)
  - 1–199 47%
  - 200–499 37%
  - 500+ 16%

**Number of sites**

- Base = 98 (Health systems)
  - 1–5 29%
  - 6–20 32%
  - 21+ 40%

**Number of physicians**

- Base = 88 (Physician organizations)
  - 1–9 34%
  - 10–49 30%
  - 50+ 36%

**Region**

- MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin
- SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware
When asked whether the results of the HealthLeaders Media Payer-Provider Strategies Survey warn of contentious relationships and indicate the presence of an emerging foundation for sharing risk, Alan J. Murray, president and CEO of North Shore-LIJ CareConnect Insurance Company, Inc., of East Hills, New York, says, “I don’t necessarily see that there is a seismic shift in the trust level.”

CareConnect is a provider-owned health plan that was created by North Shore-LIJ Health System in 2013, with a network that includes more than 16,000 providers at hospitals and physician practices throughout downstate New York. A principal point of interaction between payers and providers has been the submission of claims by the provider and the adjudication and payment of claims by the payer. These are not simple transactions—they reflect both the complexity of care and the complexity of the insurance business.

Although some of the back-and-forth is due to errors on the part of one side or the other (e.g., coding errors), as Murray suggests, trust can be a problem. More than one-third (39%) of providers say that trust with commercial payers needs to be improved.

While lack of trust is a significant problem, a number of other concerns come before it on a list of aspects of reimbursement that need to be improved.
improved, including accuracy of payments (58%), which is at the top of the list, and accuracy of adjudication, cited by 43%.

Broadly speaking, healthcare reform directs the industry to become responsible for patient health, which means providers need to become familiar with the risk assessment functions that are fundamental to the insurance business. The factors for doing business together under fee-for-service involve a complex but known set of steps. Going forward, payers, and perhaps more so providers, are going to have to feel their way. Many providers will depend on payers to be their guides, and the fundamental payer-provider reimbursement transaction can be considered a shaky foundation that warrants attention. “Trust is about understanding, above all,” says Murray, an advisor to this Intelligence Report. “It’s hard to trust when you don’t understand.”

Recognizing that it is competing in a market against large organizations with longstanding working relationships, CareConnect is competing on price and customer service. The reimbursement process is one area in which CareConnect offers improvements.

“A claim denial is a failure of the system, and we want to get ahead of that,” Murray says. With claims denials, CareConnect initiates a dialogue between the attending physician who ordered the procedure and, for instance, the attending’s department chair. “Whatever the outcome of that conversation, we approve. Then we update my medical policies to reflect the decision prospectively.

“It’s about linking and aligning the incentives, not just financially but also from an efficiency and practicality basis, so that physicians want to partner with an insurance company, and they want to be part of something that is approaching healthcare in a different light,” Murray says. “Their members—patients—are much happier, too, because we’re doing things like scheduling their appointments. We are making it simple for their patients to get services from our network.”

A main challenge for providers is that they struggle at the receiving end of reimbursement changes. Their inability to increase fees despite the payers’ ability to increase rates is a top area of conflict for nearly half of all respondents (49%), including 63% of those from physician organizations. In payer negotiations, hospitals have more strength than physician organizations, says Hal Teitelbaum, MD, JD, MBA, managing partner and CEO of Crystal Run Healthcare, a Middletown, New York–based physician organization with more than 300 physicians in 40-plus medical specialties.

“I think hospitals have still been able to demand some increases from payers. Physicians are less consolidated, and certainly the small groups have not been able to negotiate with the payers effectively.”

—Hal Teitelbaum, MD, JD, MBA
“I think hospitals have still been able to demand some increases from payers. Physicians are less consolidated, and certainly the small groups have not been able to negotiate with the payers effectively,” Teitelbaum says. The squeeze that physician organizations are under provides Crystal Run with an opportunity to grow its network. “To be perfectly frank, one of the things that helps us in our growth is that physicians feel that their reimbursements are either flat or decreasing while their overhead is increasing.”

Physician organizations and private practices that are not successful in making alliances with other providers must face payer revenue pressure without leverage and may have more of a challenge maintaining their patient base as value-based care efforts advance. For Crystal Run, providing value-based care has reduced the average number of visits per patient by 8% over the past three years. Teitelbaum, an advisor to this Intelligence Report, says, “That can result in decreased compensation to physicians unless unit price is increased or unless they can backfill with more patients. Fortunately for us, we’ve been able to fill these slots that have been emptied through more efficient care. And we have been working on value-based compensation programs with our payers. But if you can’t do those things, you’re going to be badly hurt.”

The role of data and analytics in payer-provider relationships.

Providers recognize the role of IT and analytics in meeting the care delivery and financial demands of healthcare reform, and they see that payer data offers important insights in those areas. Overall, 43% of survey respondents are now using payer data to better understand patients’ care experiences, including 52% of health systems. Nearly as many (35%) now use payer data in support of their organization’s risk assessment function. And access to data tops the list of payer activities that healthcare leaders find beneficial.

Larger organizations that might be more advanced in addressing population health issues and participating in at-risk payment programs favor risk-adjusted patient data slightly. Forty-six percent of organizations with net patient revenue of $250 million or above say that access to risk-adjusted patient data is beneficial, compared to 40% of those at that revenue level who say that access to aggregate claims data is beneficial. Teitelbaum explains that risk-adjusted data is actionable. “If I have patient-specific data and it’s risk-adjusted, I know which patients need my attention—those are the ones that I need to apply most of my resources to.” Aggregate data, he says, is useful for determining performance status. “I think that many physicians might say they need a scorecard to calibrate their behavior.”

“Trust is about understanding, above all. It’s hard to trust when you don’t understand.”

—Alan J. Murray
As one might expect, the top items providers would like to achieve or improve in their next negotiation with payers are related to data. In particular, 50% say they would address metrics used to determine quality performance. And 44% include metrics used to determine value parameters among the areas they would like to improve in their next payer negotiation.

Teitelbaum talks about the burden of metrics. “We’re following over 170 performance measures,” he says. “It takes resources to do these things. You have to set it all up, and it takes business intelligence people and analytics skills. So you are using real horsepower.” Some payers are more understanding than others about how much work it is to deliver performance data. “I think some payers understand what the issues are and are willing to work with you,” Teitelbaum says. “Frankly, some don’t care. ‘We want this number. We want this particular metric,’ they say.”

Are payers ready to work with providers?

Diane Holder is CEO of the UPMC Health Plan, a Pittsburgh-based insurance services division owned by UPMC with a network that includes more than 125 hospitals and more than 11,500 physicians throughout Pennsylvania and parts of Ohio, West Virginia, and Maryland. As a payer, Holder, lead advisor for this Intelligence Report, supports providers because the insurance company relies on their performance for member retention. “The dollars that come into the plan side of UPMC are in excess of $5 billion a year in prepaid dollars, from employer payments, Medicare, Medicaid. All of that comes to me capitated. I need to manage those costs for whatever those members are, right? I’ve got to manage those costs under the capitated dollar, and I have to make sure that quality outcomes and customer satisfaction are very high, because I want customers to stay with us, and I want my Medicare and Medicaid members to feel like we’re a really good plan. So we work hand in glove with our clinical delivery system to improve things.”

But not all payers take that approach. Teitelbaum says that this year, Crystal Run expects to have “about 50% of all of our patients covered by some form of value-based payment relationship,” and the practice intends to increase that percentage. “Although we literally have dozens of payers of one kind or another, our top 10 payers account for most of our work. Our top six commercial payers are the ones involved with us in commercial shared savings arrangements. Some have behaved very admirably and have become great partners in this endeavor. And others we have to drag kicking and screaming.” Crystal Run has leverage, though. “Sometimes it comes down to simply saying, ‘No, we’re not going to negotiate with you over rates anymore. We’re going to negotiate with you over value-based

“I think hospitals have still been able to demand some increases from payers. Physicians are less consolidated, and certainly the small groups have not been able to negotiate with the payers effectively.”

—Hal Teitelbaum, MD, JD, MBA
Getting closer to the premium dollar.

Participation in programs that involve at-risk performance is far from universal—38% report that their organization is involved in activities such as an ACO, with both upside and downside risk. Nearly the same percentage (35%) participate in accountable payment programs with upside risk only, while 20% are in a program with downside risk only. In all cases, higher percentages of health systems than hospitals or physician organizations are involved in risk-oriented compensation programs.

Relatively few health systems (12%) say they are not involved in at-risk programs, compared to 23% of hospitals and 28% of physician organizations. Murray identifies the two principal strategies that providers can take. “One school of thought is to get in early, experiment, and make the most of it. The other is let others lead, and be a follower, taking advantage of the fee-for-service world as long as possible. It depends on individual circumstances and the executive team of the hospital as to which direction to go.”

However, the requirement today, according to Teitelbaum, is to push hard at value-based activities. “Some people have said, ‘No, no, we’re going to hang on to this old way as long as possible.’ If you do that, you’re not going to convince payers that you’re moving in the right direction.

You’ve got to demonstrate to the payers, frankly, that you can actually bend the cost curve while improving quality.”

Neither of those principal strategies is particularly aggressive. Complicating the decision is what Holder calls the glide path, which addresses the rate at which the industry makes the transition from volume to value. “The industry is not flipping overnight from fee-for-service to capitation en masse,” she says. “That just isn’t going to happen. What people are struggling with is the glide path in moving from volume to value. There is tremendous pressure for private and public payers to get involved in risk arrangements or value-based payment models.

“You do need a pool of money, or a denominator that you are in charge of, so that if you save money, you can reinvest in the next thing you have to do and still have a margin attached to that,” Holder says. “Organizations look for strategies that are incremental in nature that allow them to move from fee-for-service to a value-over-volume strategy.”

ACOs, bundled payments, shared savings—these are some of the incremental steps that expose providers to value-based care and the assumption of risk. Early steps are supposed to lead to next steps. On
that path, at some point, providers recognize that when they deliver care in a more efficient and less costly way, their out-of-pocket costs increase as they incur the costs of modifying and enhancing care, while, ironically, if they are successful at delivering value-based care and their patient population is healthier, their revenue will decrease as well.

“The better job we do with patients, the less often we see them,” says Teitelbaum. “We can sort of put ourselves out of business. At least at the current time, the people who are benefiting from this most, besides our patients, are the payers.” Some can compensate for a portion of such revenue shortfalls in the old-fashioned way, by caring for additional patients or adding more preventive services, but as the industry becomes more concentrated, opportunities to grow revenue by attracting additional patients are fewer. Acute care environments are already seeing reductions in patient volumes as more patients seek care in ambulatory and outpatient environments. And as that trend advances, the overall acuity level of patients who are admitted is likely to increase. The direction is toward capitated payments or shared risk, which can spur activity toward clinical integration.

From the provider’s perspective, there are two principal avenues to tap into for more of the health plan revenue stream. One path is to enhance one’s stature as a provider and qualify to participate in what are becoming increasingly narrow networks. The other avenue is to participate as a payer. These principal avenues are not mutually exclusive—organizations can and do pursue both.

Network membership means access to patients.
Teitelbaum explains how payer decisions based on provider performance become a powerful incentive. “Providers have to be accountable. I am a believer that if we’re going to improve healthcare in terms of quality, value, and cost, we are going to have to do it using so-called high-value networks.”

As Crystal Run expands, the organization makes network decisions. “First and foremost, you don’t get to be a tier-one provider in my network unless you are able to demonstrate quality,” Teitelbaum says. “Next, if I have three providers of equal quality but two of them are doing it at significantly lower cost, then frankly that’s my tier-one network.”

One-third (34%) of survey respondents say that negotiations regarding network membership are a source of conflict with payers, and 32% say that tiered networks are a source of conflict. Teitelbaum has a degree of sympathy for those who don’t make the cut, but only a degree. “On one hand, I feel bad for providers who are tier three or tier four. But on the other hand, we all have the opportunity to work hard, improve our quality, and do so in a cost-effective manner,” he says. “So as long as it’s
a level playing field, I think the concept of a high-value network is what’s going to motivate some providers to do the work they need to do to improve quality and become more efficient.”

The appeal of being the payer.
At the same time that network inclusion is a motivating factor for improving performance and demonstrating value, tightening networks cause providers to examine their lack of standing with payers.

“Traditionally, decisions on networks are made by insurance companies who offer these various networks to their membership,” Holder explains. “A provider may say, ‘Why do they get to decide? Why don’t I get to decide? I’m the product. I’m the doctor. I’m the hospital. I mean, shouldn’t I be able to chart my own destiny?’ ”

It’s not just a matter of control, of course. Providers investigate participating in the insurance business because they are looking for relief from factors that are pushing at their bottom lines from two sides. Holder continues, “Because there’s going to be a lot of revenue compression and a lot of downward pressure on cost, the higher you are on the food chain regarding the premium, the more revenue can come to you, as opposed to giving it to the insurance company. If I’m going to improve quality of care and I’m going to take cost out, then who should get the savings associated with that?”

To consider becoming a payer, a provider organization has to bring to the party a large enough clinical practice and considerable financial strength. Says Holder, “You really can’t do it if you’re small, even if you wanted to. You have to have enough value to offer the market in terms of a network. When people are buying coverage, they really are buying access to clinical delivery systems and all the associated administrative things. So if you don’t have enough market mass, it’s not really doable.”

Survey results reinforce Holder’s perspective. More than one-quarter of health systems (26%) own or operate a payer business unit or health plan, a higher percentage than hospitals (16%) or physician organizations (7%). In addition, a higher percentage of health systems (29%) are considering establishing or acquiring a payer business unit or health plan, compared to 14% of hospitals and 10% of physician organizations.

Banding together and contracting for insurance services may provide a way for the not-so-large to, as they say, move closer to the premium dollar. Holder describes that method. “Smaller organizations within a geography start to align. Maybe they don’t corporately integrate, but they might start aligning to form a network.”
Such networks can contract with a payer to offer a plan, with the payer acting as a third-party administrator, and the provider network delivering access to members (often employees) and delivering care. Indeed, North Shore-LIJ’s early forays into the payer environment were with such contracts, first with Aetna, then BlueCross BlueShield, and later with UnitedHealthcare. A disadvantage of such arrangements is that having a third-party administrator running the insurance business may not allow the provider hands-on exposure to insurance business factors, so organizational learning would be limited.

Noting that 28% of respondents have examined operating a payer business unit and decided not to pursue it, and that 21% are not participating in at-risk programs, Murray wonders about future revenue for such providers in light of the changing payer-provider landscape. Those who are not involved are not connected with an important source of know-how, information that may be needed to inform their decisions.

“I guess the question I have for them is, how do they control their own revenue stream?” Murray says. “If you decide to partner with an insurance company, either for an insurance product or with an ACO, in order to do that partnering you have to know their business and what influences them. And it is a very, very different universe than what influences a typical provider.”

Those who pursue at-risk programs begin a hands-on learning process, which, when extended, can translate into increased ability to differentiate good deals from bad. Such exposure, Murray says, “provides tremendous insight into the other half of the industry, so that when an insurance company knocks on the door and has a new strategy, the provider can now understand it from that insurance company’s perspective and can make decisions that are no longer made in a vacuum, and they understand all of the ramifications of those deals vertically.”

Murray is emphatic that, one way or another, providers need to understand the factors for doing business in the payer world. Participating in value-based medicine, he says, involves investments in population health, coordination of care, case management, and disease management. From a care-delivery perspective, providers understand. But payers know these same aspects of care from a cost and risk perspective. Providers have to invest in understanding data and understanding risk from a payer’s perspective.

According to Murray, “If you’re delegated for risk, you need to understand underwriting and have actuarial skills, because if you don’t...”

“What people are struggling with is the glide path in moving from volume to value. There is tremendous pressure for private and public payers to get involved in risk arrangements or value-based payment models.”

—Diane Holder
understand how the premium is formed, how can you be sure you’re reconciling the right premium for your upside or downside risk? These are investments providers will have to make one way or the other if they are moving away from fee-for-service.”

In the midst of paying attention to revenue and risk, Holder reminds us that the patient is part of the formula. “Doctors and hospitals should try to make sure that as they build their models they have partners who own the premium side who will partner with them to figure out the best quality of care, the needs of the patient population, and how to engage consumers in being active participants in their own care,” she says. “The member patient also is a critical part of the arrangement. They have to be engaged in their care, doing the right things to help improve their health and manage costs appropriately.”

Although payers have skills that let them quantify risk, providers know patient care, and are in position to help the patient with what Teitelbaum calls health logistics. “Payers basically have one lever—insurance risk—which consists of underwriting risk and pricing risk,” he says. “As providers, we have an additional lever: performance. We have performance risk. This whole new world of healthcare is about doing a better job managing patients. The heavy lifting for providers is whether we can provide healthcare services better because we’re taking performance risk, we’re managing the care, and we’re handling the health logistics of this population. That’s really what we can do better than the average payer.”

Health logistics at Crystal Run go far beyond care coordination, and providers need to decide, as Crystal Run has, in which ways they should be horizontally integrated. Crystal Run has established an integrated network of providers, warmed to ACOs as those programs emerged in the past decade, and now is launching a payer business unit. Says Teitelbaum, “We are a health logistics organization, helping to coordinate and facilitate a large variety of complex operations, resources, personnel, etcetera, for the ultimate benefit of our patients. We see our product these days as not being healthcare; we see our product as being health outcomes.”

Behind Crystal Run’s pursuit of a large provider network and its foray into the insurance business is recognition that providers will be responsible for the evolution of healthcare into value-based models. Says Teitelbaum, “One of our principles at Crystal Run Healthcare is very much that physicians have an important role to play in the healthcare system, beyond simply hands-on services, which itself is really, really important.”

Recognition of the difficulties that both patients and providers have with insurance companies has become a source of differentiation for CareConnect, which addresses, among other things, the logistics of payment transactions. Says Murray, “Our differentiator is service experience. That’s almost impossible for most of my potential consumers to even believe that we actually can do this. The bar is set so low in healthcare, when you say you’re going to be a customer service company
inside healthcare, especially health insurance, nobody believes you. Even my
distribution channel just doesn’t believe it, although they’re starting to.

“For me, the combination of the ability to manage the medical dollar as
well as the ability to provide members an unsurpassed experience is what
is going to grow my market share over time,” Murray says. At the end
of 2014, CareConnect served 12,500 members. Murray expects to have
40,000 members by the end of this year.

**Learn, and learn to trust.**

As noted above, more than one-third of healthcare leaders (39%) say
that trust is an aspect of the reimbursement process that needs to be
improved. Although there can be a great deal of complexity in such
transactions, we should consider the reimbursement process to be basic
to the payer-provider relationship. If there is such a degree of mistrust
about a fundamental transfer of funds, how are payers and providers
going to address value-based care together? According to Murray,
providers need to become familiar with the insurance business.

“If you’re going to be in a relationship where you are taking some sort
of risk, you need to be able to trust the partner that you’re interacting
with,” he says. “And in order to trust the partner, I firmly believe that you
have to have knowledge of the partner’s activities so that you can build
that trust. Like it or not, providers are going to have to gain a significant
knowledge base in what has traditionally been a core competency of
insurance companies.”

Providers need to learn what is, for them, a new business. Avoidance
may leave providers without the ability to make informed decisions.
Says Teitelbaum, “We as physicians have to stop whining and we have
to start doing. If we’re not happy with the healthcare system, we need to
work to change it. For Crystal Run to be part of that change, our practice
had to grow in size, scope, and geography, and we had to differentiate
ourselves based on quality and service. We had to bring primary care
into the practice in a very large way. Ultimately, we needed to become
unavoidable. We needed to become a force in healthcare.”

**Michael Zeis** is senior research analyst for HealthLeaders Media.
He may be contacted at mzeis@healthleadersmedia.com.
**FIGURE 1 | Top Areas of Conflict Between Organization and Payers**

**Q** | Which of the following are the top three areas of conflict between your organization and payers?

<table>
<thead>
<tr>
<th>Area of Conflict</th>
<th>Total Responses</th>
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</thead>
<tbody>
<tr>
<td>Payers can increase rates, we can’t increase fees</td>
<td>49%</td>
</tr>
<tr>
<td>Payers’ failure to adequately address cost curve</td>
<td>45%</td>
</tr>
<tr>
<td>Plan redesign with negative consequences</td>
<td>39%</td>
</tr>
<tr>
<td>Negotiations over in-network/out-of-network status</td>
<td>34%</td>
</tr>
<tr>
<td>Tiered networks</td>
<td>32%</td>
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<tr>
<td>Cost-focused preferred provider designations</td>
<td>24%</td>
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<tr>
<td>Inadequate time frame for providers to assume risk</td>
<td>18%</td>
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<td>7%</td>
</tr>
<tr>
<td>None</td>
<td>4%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Base = 304, Multi-Response**

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**TAKEAWAYS**

- The inability to increase fees despite the payers’ ability to increase rates is a top area of conflict for nearly half (49%), including 63% of physician organizations. This affects small (80%) and medium (62%) more than large (47%) physician organizations. One respondent added this comment: “[It’s] take it or leave it—no negotiation.”

- Overall, 32% cite tiered networks among their top areas of conflict. Forty-one percent of health systems say the same, which is just about as many mentions as the inability to increase fees, included by 42%.

**WHAT DOES IT MEAN?**

The inflexible nature of reimbursements for care affects physician organizations in particular. Health systems, which arguably have wider networks, have placed tiered networks in a virtual tie with rate inflexibility as an area of conflict.

Many respondents made use of the “Other” category. A number say that some aspect of claims processing, authorization, or payment causes conflict. Because reimbursement is the foundation of the relationship between provider and payer, perhaps it is an expected source of friction. Several respondents commented that access to data is a problem. A few are concerned by issues related to performance, such as linking metrics to patient outcomes.
FIGURE 1 (continued) | Top Areas of Conflict Between Organization and Payers

Q | Which of the following are the top three areas of conflict between your organization and payers?

BUYING POWER REPORT SAMPLE CHARTS | CLICK HERE TO ORDER!

Clinical products

- Payers can increase rates, we can’t increase fees
- Payers’ failure to adequately address cost curve
- Plan redesign with negative consequences
- Negotiations over in-network/out-of-network status
- Tiered networks
- Cost-focused preferred provider designations
- Inadequate time frame for providers to assume risk
- Payer goes public when negotiations stall
- None
- Don’t know

Financial services

- Payers can increase rates, we can’t increase fees
- Payers’ failure to adequately address cost curve
- Plan redesign with negative consequences
- Negotiations over in-network/out-of-network status
- Tiered networks
- Cost-focused preferred provider designations
- Inadequate time frame for providers to assume risk
- Payer goes public when negotiations stall
- None
- Don’t know

Consulting services

- Payers can increase rates, we can’t increase fees
- Payers’ failure to adequately address cost curve
- Plan redesign with negative consequences
- Negotiations over in-network/out-of-network status
- Tiered networks
- Cost-focused preferred provider designations
- Inadequate time frame for providers to assume risk
- Payer goes public when negotiations stall
- None
- Don’t know

Outsourcing services

- Payers can increase rates, we can’t increase fees
- Payers’ failure to adequately address cost curve
- Plan redesign with negative consequences
- Negotiations over in-network/out-of-network status
- Tiered networks
- Cost-focused preferred provider designations
- Inadequate time frame for providers to assume risk
- Payer goes public when negotiations stall
- None
- Don’t know

Executive search

- Payers can increase rates, we can’t increase fees
- Payers’ failure to adequately address cost curve
- Plan redesign with negative consequences
- Negotiations over in-network/out-of-network status
- Tiered networks
- Cost-focused preferred provider designations
- Inadequate time frame for providers to assume risk
- Payer goes public when negotiations stall
- None
- Don’t know

Legal services

- Payers can increase rates, we can’t increase fees
- Payers’ failure to adequately address cost curve
- Plan redesign with negative consequences
- Negotiations over in-network/out-of-network status
- Tiered networks
- Cost-focused preferred provider designations
- Inadequate time frame for providers to assume risk
- Payer goes public when negotiations stall
- None
- Don’t know
**FIGURE 2 | Top Beneficial Payer Activities for Organization**

**Q |** What are the top three payer activities that provide your organization with the most benefit?

<table>
<thead>
<tr>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to risk-adjusted patient data</td>
</tr>
<tr>
<td>Access to aggregate claims data</td>
</tr>
<tr>
<td>Health and wellness program</td>
</tr>
<tr>
<td>Patient navigator program</td>
</tr>
<tr>
<td>Waiving selected medical necessity requirements</td>
</tr>
<tr>
<td>Public or commercial ACO</td>
</tr>
<tr>
<td>Fees for patient wellness assessments</td>
</tr>
<tr>
<td>Outreach to patient cohorts</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Don't know</td>
</tr>
</tbody>
</table>

Base = 304, Multi-Response

**TAKEAWAYS**

- More than one-third include access to risk-adjusted patient data (39%) and aggregate claims data (36%) among the payer activities that provide them with the most benefit. Nearly half of medium-revenue and high-revenue organizations (46% of each) say risk-adjusted patient data is a benefit, compared to 33% of low-revenue organizations.

- A lower percentage of small physician organizations (23%) than medium (42%) or large (50%) include risk-adjusted patient data as a benefit. However, 33% of small physician organizations include aggregate claims data among their top payer benefits, the item identified most frequently by such organizations.

- One-third (32%) of low-revenue organizations say that waiving selected medical necessity requirements is a top payer benefit, higher than medium- (19%) and high-revenue (23%) organizations.

**WHAT DOES IT MEAN?**

Smaller organizations tend to place more emphasis on payer activities that facilitate or increase reimbursements. Because they are likely to be farther along on the path to capitated payments, larger organizations tend to benefit more from access to data, especially risk-adjusted patient data that can guide patient-specific actions. Aggregate claims data is more often used for benchmarking. Also related to capitation and risk, higher percentages of larger organizations see payer sponsorship of ACOs to be a benefit.

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